MEDI-CAL UPDATE

Pharmacy
Bulletin 566

Billing and Policy
Pharmacy Bulletin 566 **September 2003**

Contents

Articles with related Part 1 Manual Replacement Pages may be found in the "Program and Eligibility" bulletin. Articles with related Part 2 Manual Replacement Pages may be found in the "Billing and Policy" bulletin. The Medi-Cal Update *may not always contain a "Billing and Policy" section.*

HIPAA: Provider Manual Updates

The September 2003 Health Insurance Portability and Accountability Act (HIPAA) implementation resulted in the following changes in the Medi-Cal provider manuals. All changes are effective for dates of service on or after September 22, 2003.

Important: When you follow the remove and replace instructions in this bulletin and update your manual, please retain the pages you remove. Place them after the *Appendix* tab at the back of your manual. These page will help you bill for services that you rendered prior to September 22, 2003.

The following information is provided for pharmacies that bill for supplies and select services on the *HCFA 1500* claim form.

New HIPAA In Review

A handy *HIPAA In Review* guide has been included in this bulletin for you to insert in your provider manual at the end of the *HCFA 1500 Completion* section. This guide summarizes important *HCFA-1500*-related changes that resulted from the September 2003 phase of HIPAA implementation.

Place of Service Codes

Place of Service Field (Box 24B)

24 A						B
DATE(S) OF SERVICE						Place of Service
FROM			TO			
MM	DD	YY	MM	DD	YY	
						XX

Local Medi-Cal Place of Service codes are being replaced with national Place of Service codes, which are entered in the same box (24B) as previously entered.

Place of Service codes are defined by the Centers for Medicare and Medicaid Services (CMS).

Manual Changes

- Medi-Cal Place of Service code values are changed to national Place of Service code values.
- A *Code Correlation Guide* showing the relationship between Medi-Cal Place of Service and national Place of Service codes is added at the end of the *HCFA 1500 Completion* section to help you understand how local Place of Service codes are being converted to national Place of Service codes.

Please see **HIPAA,** *page 2*

HIPAA *(continued)*

Billing Limit Exception to Delay Reason Codes

COB Field (Box 24J)

I	J	K
EMG	COB	RESERVED FOR LOCAL USE
	XX	

Local Medi-Cal billing limit exception codes are being replaced with national delay reason codes. Delay reason codes are entered in Box 24J, the same box where billing limit exception codes were entered.

Use of national delay reason codes is mandated by HIPAA.

Manual Changes

- A *Code Correlation Guide* showing the relationship between billing limit exception and delay reason codes is added at the end of the *HCFA 1500 Completion* section to help you understand how Medi-Cal billing limit exception codes have been converted to national delay reason codes.

Modifiers

Procedures, Services, or Supplies Field (Box 24D)

D		E
PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE
X X X X X 2 6	**4 7 6 0 6 2**	

Up to four modifiers may be entered on HCFA 1500 claims. All modifiers (-26, -47, -60 and -62 in the preceding example) must be billed immediately following the procedure code, with no spaces, in the Procedures, Services or Supplies/Modifier field (Box 24D).

Manual Changes

- The *HCFA 1500 Completion* section is updated to include instructions for billing with up to four modifiers.
- When billing for services rendered to recipients who are patients in subacute care facilities, you must enter the Place of Service code “99” in the *Place of Service* field (Box 24B) and modifier -HA (pediatric) or -HB (adult) in the last-used modifier field.

Please see **HIPAA,** *page 3*

HIPAA *(continued)*

"From-Through" Billing

Date(s) of Service Field (Box 24A)

24 A					B
DATE(S) OF SERVICE					Place of Service
FROM			TO		
MM	DD	YY	MM	DD	YY	
0 9 2 2 0 3			0 9 3 0 0 3		

"From-through" services with a "from" date of service on or after September 22, 2003 are billed with national codes. "From-through" services with a "from" date prior to September 22, 2003 are billed with local Medi-Cal codes. (Please note, the "through" date is "to" on the HCFA 1500.)

Guidelines

Changes for the September 2003 phase of HIPAA implementation established the following guidelines:

- Claims with dates of service on or after September 22, 2003 must be submitted with national Place of Service and delay reason codes.
- Claims for services prior to September 22, 2003 must be billed with local Medi-Cal Place of Service and billing limit exception codes.
- Claims for services rendered on dates of service that include both pre- and post-September 22, 2003 dates must be billed on separate claims (split billed) with national codes on one claim and local Medi-Cal codes on another.

"From-Through" Exemption

Claims for services that require "from-through" billing (identified in policy sections) do not require the split billing. They are billed as indicated in the italicized text under the preceding diagram.

Manual Changes

- The *HCFA 1500 Special Billing Instructions* section is updated to include the preceding "from-through" information.

2003 CPT-4 and HCPCS Updates: Implementation September 22, 2003

The 2003 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II and local Level III codes are effective for Medi-Cal for dates of service on or after September 22, 2003. Some of the policy changes are highlighted below.

DURABLE MEDICAL EQUIPMENT

TAR Requirement: HCPCS Code E0442, E0434 and E0435
Claims for liquid oxygen codes E0434 (portable liquid oxygen system, rental), E0435 (portable liquid oxygen system, purchase) and E0442 (oxygen contents, liquid) require prior authorization. A *Treatment Authorization Request* (TAR) is required for code E0442 when more than 50 pounds are needed by a patient during a calendar month.

The updated information is reflected on manual replacement pages dura bil oxy 3, 6 and 8 (Part 2) and dura cd 7 (Part 2).

HCPCS Code E0483
HCPCS code E0483 (air-pulse generator system) replaces local codes X3206 and X3212. All medical policies for X3206 and X3212 are applicable to E0483. Reimbursement for E0483 is for rental only and must be billed with modifier -Y6 (rental with sales tax). The rental reimbursement rate for E0483 includes an amount that allows for the replacement of the vest every two years at no additional cost to the Medi-Cal program. New code A7025 (replacement vest) is not a Medi-Cal benefit.

The updated information is reflected on manual replacement pages dura bil oxy 1 (Part 2) and dura cd 9 (Part 2).

HCPCS Code S8265
HCPCS codes S8265 (Haberman Feeder) is a Medi-Cal benefit with the following restrictions:

- Maximum age: 1 year old
- Frequency limit: Two per month
- Diagnosis restriction: 749.00 – 749.25 (cleft lip/palate), 758.0 (Down Syndrome) and 779.3 (feeding problems of the newborn)

The updated information is reflected on manual replacement page dura bil dme 2 and 11 (Part 2).

ORTHOTICS AND PROSTHETICS

Deleted and Replacement Codes
HCPCS codes L5660, L5662, L5663 and L5664 are replaced by K0556 – K0559.
The updated information is reflected on manual replacement page ortho cd2 5 (Part 2).

Reimbursement Restrictions for New HCPCS Codes
The following HCPCS codes have Medi-Cal reimbursement restrictions:

- K0556 – K0559 are limited to twice within a six-month period
- L5781, L5782, L5848, L5995, L6025, L6638, L6646, L6647, L6648, L7367 and L7368 are limited to once within a 12-month period
- L0450 – L0490, L1652, L1836, L1901, L3651, L3652, L3701, L3762, L3909, L3911, L4386 and S1040 are limited to twice in a 12-month period
- L1836 and L1901 are reimbursable to podiatrists

Please see **HCPCS,** *page 5*

HCPCS *(continued)*

HCPCS Code S1040
New HCPCS code S1040 (cranial molded helmet) is a new Medi-Cal benefit, subject to prior authorization, with the following restrictions:

- Maximum age: 2 years of age
- Frequency limit: Two in 12 months
- Diagnosis restrictions: 754.0 (plagiocephaly) and 756.0 (craniosynostosis)
- Requires a TAR, which must include the name and address of the FDA-approved lab that makes the helmet

The updated information is reflected on manual replacement page ortho 8 (Part 2).

Elimination of Benefits: Foot Inserts, Arch Supports and Elastic Stockings
Effective for dates of service on or after October 1, 2003, the following HCPCS codes will no longer be reimbursable by Medi-Cal:

- Foot Inserts: HCPCS codes L3000 – L3030
- Arch Supports: HCPCS codes L3040 – L3090, L3170
- Elastic Stockings: HCPCS codes L8100 – L8180, L8220, L8239

Treatment Authorization Requests: Requirements and Thresholds
Effective for dates of services on or after October 1, 2003, TARs will be required for the following appliances. A signed prescription from a physician, podiatrist or dentist must accompany all TARs for orthotic and prosthetic appliances.

- Orthotic appliances when the cumulative total of purchase, replacement or repairs exceeds $250 per 90-day period
- Prosthetic appliances when the cumulative total of purchase, replacement or repairs exceeds $500 per 90-day period
- Any unlisted, "By Report," or "By Invoice" appliance

Providers requesting prior authorization of bilateral appliances (-LT [left] and -RT [right]) should request the procedure for the separate sides on two lines of the TAR. Do not use any other modifiers on the TAR.

Provider Restrictions
Effective for dates of services on or after October 1, 2003, only physicians and certified orthotists and prosthetists may be reimbursed for orthotic and prosthetic appliances. In addition to physicians, certified orthotists and certified prosthetists, codes with double asterisks (**) are reimbursable to pharmacists who successfully completed the National Community Pharmacists Association (NCPA) program of Health Supports and Appliances Certification.

Compound Drugs: Claim Submission Guidelines

Required NCPDP Format for Real-Time Pharmacy Claims
Effective October 1, 2003, Medi-Cal will no longer accept pharmacy claims submitted through the Point of Service (POS) network using the National Council for Prescription Drug Programs (NCPDP) Version 3.2 format.

New Methods for Submitting Compound Drug Claims
Effective for dates of service on or after September 22, 2003, Pharmacy providers may submit claims for compound drugs (for both traditional pharmacy-compounded items, such as creams and ointments, and for home infusion compounds) using one of the following new methods:

Please see **Compound,** *page 6*

Compound *(continued)*

- The real-time Point of Service (POS) network using the NCPDP Version 5.1 standard and the pharmacy computer software
- The Real-Time Internet Pharmacy (RTIP) application, using the pharmacy computer and Internet browser
- The new paper *Compound Pharmacy Claim Form* (30-4)

The new *Compound Pharmacy Claim Form* (30-4) is now available and can be ordered by calling the Provider Support Center (PSC) at 1-800-541-5555.

Refer to the August 2003 *Medi-Cal Update* for details about the changes associated with the new billing methods. The current compound drug claim submission method will be discontinued in the near future. For more information about how to bill compound drugs using the new methods, refer to the new manual section *Compound Drug Pharmacy Claim Form (30-4) Completion* and manual section *Pharmacy Claim Form (30-1): Special Billing Instructions.*

Billing for Medical Supplies and Empty Containers
For dates of service on or after October 1, 2003, medical supplies and empty containers used to prepare compounds must be billed separately from compound drug claims on either the *Pharmacy Claim Form* (30-1) or the *HCFA 1500* claim form using current Medi-Cal codes for medical supplies. Such items may no longer be billed as part of a compound drug claim and will not be reimbursed as ingredients using either the current or new compound drug billing methods.

Prior authorization is still required for any item that normally requires a *Treatment Authorization Request* (TAR), regardless of whether the item was used in the preparation of a compound or not.

Prior authorization is required for single-ingredient (sterile transfer) compound drug claims for more than seven containers. Prior authorization is also required for multiple-ingredient compound drug claims for more than 20 containers.

Code I Rules for Compound Drug Claims
The Code I limit of 30 days for parenteral nutrition and intravenous (I.V.) lipids is now standardized to 10 days so that all I.V. drugs have the same Code I restriction. Claims satisfying the Code I limit for I.V. drugs must contain the hospital discharge date in the *Hospital Discharge Date* field (Box 38) of the new *Compound Pharmacy Claim Form* (30-4). Electronic compound drug claims must also include the hospital discharge date to satisfy the Code I limit.

TAR Requirements for Compound Drug Claims
When obtaining prior authorization for a compound drug using a paper TAR, continue to enter "99999999996" in the *NDC/UPC or Procedure Code* field (Box 11) and round up the total quantity to a whole number in the *Quantity* field(Box 12) since the TAR does not allow for metric decimal quantities.

The updated information is reflected on manual replacement page tar comp 11 (Part 2).

POS Device and RTIP Reject Codes: Updates

Effective September 22, 2003, the National Council for Prescription Drug Programs (NCPDP) reject codes for claims will be updated to include claims submitted for compound drugs. *This information is reflected on manual replacement pages reject cd pos 2 thru 6 and 9 thru 11 (Part 2).*

Provider Orientation and Update Sessions

The Family PACT (Planning, Access, Care and Treatment) Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

To be eligible to enroll as a medical provider in the Family PACT Program, the Medi-Cal provider seeking enrollment is required to attend a Provider Orientation and Update Session. When a group provider wishes to enroll, a physician-owner must attend the session. When a clinic wishes to enroll, the medical director or clinician responsible for oversight of the medical services rendered in connection with the Medi-Cal provider number is required to attend.

Office staff members, such as clinic managers and receptionists, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain up to date with program policies and services.

Note: Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

Dates and Locations

The following dates and locations are scheduled for the remainder of 2003:

September 16, 2003 **Visalia** Holiday Inn and Conference Center 9000 West Airport Drive Visalia, CA 93277 **For directions, call** (559) 651-5000	**October 1, 2003** **Pasadena** Sheraton Pasadena Hotel 303 East Cordova Street Pasadena, CA 91101 **For directions, call** (626) 449-4000	**October 28, 2003** **Emeryville** Holiday Inn Bay Bridge 1800 Powell Street Emeryville, CA 94608 **For directions, call** (510) 658-9300
November 5, 2003 **Ventura** Ventura Beach Marriott 2055 Harbor Boulevard Ventura, CA 93001 **For directions, call** (805) 643-6000	**November 19, 2003** **Redding** Red Lion Hotel Redding 1830 Hilltop Drive Redding, CA 96002 **For directions, call** (530) 221-8700	**December 4, 2003** **Riverside** Riverside Marriott 3400 Market Street Riverside, CA 92501 **For directions, call** (909) 784-8000

Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials.

Please see **Family PACT**, *page 8*

Family PACT *(continued)*

Provider Orientation and Update Session Registration

Providers should call the Center for Health Training at (510) 835-3795, ext. 113, to register for the session they plan to attend. Providers must supply the name of the Medi-Cal provider or facility, the Medi-Cal provider number, a contact telephone number, the anticipated number of people who will be attending and the location of the orientation session. At the session, providers must present their Medi-Cal provider number, medical license number and photo identification. Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not the individual provider number or license number.

Completing the Provider Orientation and Update Session

Upon completion of the orientation session, each prospective new Family PACT medical provider will be mailed a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services.

Providers arriving late or leaving early will not be mailed a *Certificate of Attendance.* Currently enrolled Family PACT providers will not receive a certificate.

Family PACT Contact Information

For more information regarding the Family PACT Program, please call the Health Access Programs (HAP) Hotline at 1-800-257-6900 from 8 a.m. to 5 p.m., Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

Instructions for Manual Replacement Pages
Pharmacy Bulletin 566 **September 2003**

Part 2

Remove and replace:	Contents i/ii *
	blood 7 thru 9
	cif co 1/2
Remove section:	*Compounded Drug Attachment Completion*
Insert:	compound comp 1 thru 14 * *(new)*
	compound ex 1 thru 6 * *(new)*
Remove and replace:	drugs maic fac 13/14 *
	dura 11
	dura bil dme 1/2, 11 thru 15
Remove:	dura bil oxy 1 thru 14
Insert:	dura bil oxy 1 thru 13
Remove:	dura cd 1 thru 16
Insert:	dura cd 1 thru 17
Remove and replace:	dura ex 1/2, 5 thru 10

Notice: The September 2003 Pharmacy *Medi-Cal Update #566* was mailed to you in two parts (in separate envelopes) this month. Please watch for this second mailing containing additional pages and update your manual.

* Pages updated due to ongoing manual updates

MEDI-CAL UPDATE

Pharmacy
Bulletin 566

Pharmacy (PH) Bulletin 566 September 2003

Notice

This mailing contains:
September 2003 Pharmacy
Medi-Cal Update #566

This is the second of two mailings.

The September 2003 Pharmacy *Medi-Cal Update* #566 was mailed to you in two parts (in separate envelopes) this month. The first mailing was sent to you earlier this month and contained all the September bulletin articles, as well as a portion of the manual replacement pages.

This second mailing contains the remaining manual replacement pages.

Part 2

Remove and replace:	hcfa comp 1/2, 15 thru 22
Insert at end of *HCFA 1500 Completion* section:	*HIPAA In Review (new)* *Code Correlation Guide (new)*
Remove: Insert:	hcfa spec 1 thru 7 hcfa spec 1 thru 9 *(new)*
Remove and replace:	hcfa sub 1 thru 5
Remove: Insert:	hcfa tips 1 thru 3 hcfa tips 1 thru 4 *(new)*
Remove and replace:	iv sol spec 3 thru 5 medi non hcp 1/2
Remove: Insert:	ortho 1 thru 13 ortho 1 thru 10
Remove: Insert:	ortho cd 1 thru 27 ortho cd1 1 thru 26
Remove: Insert:	ortho cd2 1 thru 25 ortho cd2 1 thru 22
Remove and replace:	ortho ex 1 thru 7 pcf 30-1 comp 1/2, 11 thru 16 * pcf 30-1 ex 1/2 * pcf 30-1 spec 3/4 * pcf 30-1 tips 3/4 * presum 17-20
Remove: Insert:	reject cd pos 1 thru 8 reject cd pos 1 thru 11 *(new)*
Remove and replace:	subacut adu 3/4 subacut lev 1 thru 4 subacut ped 3/4 tar comp 9 thru 12 tax 3 thru 8

* Pages updated due to ongoing manual updates